SED WAIVER
PROVISIONAL PLAN OF CARE
(2019 sep 10)

(PLEASE PRINT)

(CONSUMER) ---

LAST NAME _____

FIRST NAME _____ MI _____

DOB --- MM/DD/YYYY _____

SSN _____

MEDICAID ID _____

ADDRESS _____

CITY – STATE – ZIP _____

PHONE # _____

(PARENT / LEGAL GUARDIAN) ---

LAST NAME _____

FIRST NAME _____ MI _____

ADDRESS _____

CITY – STATE – ZIP _____

PHONE # _____

The total budget amount is used to calculate the "monthly cost" on Form 3160 Section III.
Please check the box next to the SED waiver service you anticipate will be provided
in the **next thirty (30) days** starting on _____.
Calculate the cost per service and place the amount on the line provided.
Calculate the total cost for all services and place the amount on the "Total Budget Amount" line.

☐ ATTENDANT CARE ------ T1019 HK ------ 1 unit = 15 min

COST _____ FOR _____ UNITS @ 6.52 per unit

☐ INDEPENDENT LIVING / SKILLS BUILDING ------ T2038 ------ 1 unit = 1 hr

COST _____ FOR _____ UNITS @ 43.49 per unit

☐ PARENT SUPPORT TRAINING (INDIVIDUAL) ------ S5110 ------ 1 unit = 15 min

COST _____ FOR _____ UNITS @ 10.87 per unit

☐ PARENT SUPPORT TRAINING (GROUP) ------ S5110 TJ ------ 1 unit = 15 min

COST _____ FOR _____ UNITS @ 3.26 per unit

☐ PROFESSIONAL RESOURCE FAMILY CARE (crisis stabilization) ------ S9485 ------ 1 unit = 1 day

COST _____ FOR _____ UNITS @ 150.04 per unit

☐ SHORT TERM RESPITE CARE ------ S5150 ------ 1 unit = 15 min

COST _____ FOR _____ UNITS @ 6.52 per unit

☐ WRAPAROUND FACILITATION (mandatory) ------ H2021 ------ 1 unit = 15 min

COST _____ FOR _____ UNITS @ 21.75 per unit

_____ TOTAL MONTHLY COST FOR ALL SELECTED SERVICES

SIGNATURES ---

_____ _____

(Youth if 18 year or older) (Date)

_____ _____

(Parent / Legal Guardian) (Date)

_____ _____

(Wraparound Facilitator) (Date)

_____ _____

(Mental Health Center QMHP) (Date)

_____ _____

(Team Member) `(Date)

_____ _____

(Team Member) (Date)

_____ _____

(Team Member) (Date)

_____ _____

(Team Member) (Date)

_____ _____

(Team Member) (Date)

_____ _____

(Team Member) (Date)

_____ _____

(Team Member) (Date)

By my signature below, I (Parent / Legal Guardian or Youth if 18 years or older) am indicating my choice and agreement in the denial, reduction, suspension or termination of services as written in this Provisional Plan of Care. I (Parent / Legal Guardian or Youth if 18 years or older) agree to a same day notice of the changes and accept a copy of this signature page as my Notice of Action.

I (Parent / Legal Guardian or Youth if 18 years or older) understand that I have a right to appeal the decision by filing a grievance with my Medicaid Health Plan or by requesting a state fair hearing. I understand I may request a state fair hearing in writing **within sixty (60) days plus three (3) days for mailing** of this Notice of Action form.

_____ _____

(Parent / Legal Guardian or Youth if 18 years or older) (Date)